April 7, 2003

David Martinez
TWCC Medical Dispute Resolution
4000 IH 35 South, MS 48
Austin, TX 78704

MDR Tracking #: M2-03-0786-01
IRO #: 5251

___ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to ___ for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Medical Doctor with a specialty and board certification in Orthopedic Surgery. The ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

## CLINICAL HISTORY

___ is a 38-year-old woman who injured her lower back on ___ when she fell at work, landing on her buttocks. She developed pain in the low back with radiation into her left gluteal area and the left leg. This left leg pain began after the injury occurred. Later on she developed the same type pain pattern in the right leg also. She was therefore having pain in the low back with radiation down the sciatic distribution of both legs. The patient was referred to ___, a spine surgeon. She had an MRI before she was referred to ___, and that MRI demonstrated evidence of spinal stenosis, particularly located in the lower two joint levels and also central disc protrusion at L4/5 and to a lesser degree, L5/S1. The patient seemed to have evidence of neural compression. Initially, she was treated conservatively with physical therapy and anti-inflammatory medications along with muscle relaxants and pin pills. This did not give her any particular relief of symptoms. She remained unable to work. After the evaluation by ___ she was referred for epidural steroid injection. She saw ___, an anesthesiologist specializing in pain management. She received at least two epidural steroid injections but unfortunately did not get any relief at all from those injections. She continues to have low back and bilateral leg pain.

## REQUESTED SERVICE

On January 31, 2003, which was over five months after the original date of injury, ___ requested permission to do a three-level discogram at the L3/4, L4/5 and L5/S1 levels.

DECISION

The reviewer disagrees with the prior adverse determination.

BASIS FOR THE DECISION

The ___ reviewer finds that this patient is indeed a candidate for the three-level discogram that has been requested. She has gone through nearly six months of conservative treatment, including physical therapy, medication, rest and at least two epidural steroid injections. None of these have given her any relief of symptoms. Even though she does have a rather extensive amount of degenerative disc disease in the lower two levels, she is only 38-years of age, which is relatively young to have this much apparent spinal stenosis. The reviewer agrees with ___ suggestion for getting the three-level discogram at this point in time, since conservative treatment has failed to give her any relief.

___ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. ___ has made no determinations regarding benefits available under the injured employee's policy.

As an officer of ___, I certify that there is no known conflict between the reviewer, ___ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

___ is forwarding by mail and, in the case of time sensitive matters by facsimile, a copy of this finding to the treating doctor, payor and/or URA, patient and the TWCC.

Sincerely,

## YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

In the case of prospective ***spinal surgery*** decision, a request for a hearing must be made in writing and it must be received by the TWCC Chief Clerk of Proceedings within 10 days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

In the case of other ***prospective (preauthorization) medical necessity*** disputes a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5(d). A request for a hearing should be sent to: Chief Clerk of Proceedings, Texas Worker's Compensation Commission, P.O. Box 40669, Austin, TX 78704-0012. A copy of this decision should be attached to the request.

The party appealing this decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute, per TWCC rule 133.308(t)(2).

**I hereby certify, in accordance with TWCC Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to the carrier, requestor, claimant (and/or the claimant's representative) and the TWCC via facsimile, U.S. Postal Service or both on this 7th day of April 2003.**